DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CC	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155551	B. WIN			07/14/20	011
			B. ((1))		ADDRESS, CITY, STATE, ZIP CODE	l .	
NAME OF F	ROVIDER OR SUPPLIER				NNAKER STREET		
ROLLING	MEADOWS HEAL	TH CARE CENTER			ITAINE, IN46940		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0000							
	This visit was for	r the Investigation of	F0000		Submission of this Plan of		
	Complaint IN000	093406.			Correction does not constitute a		
					admission to or an agreement w		
	Complaint INIOOC	093406-Substantiated,			facts alleged on the survey repo	rt.	
	•						
	federal/state deficiencies related to the				Submission of this Plan of		
	allegation are cite	ed at F225 and F226.			Correction does not constitute a		
					admission or an agreement by the		
	Survey dates: Jul	y 13, 14, 2011			provider of the truth of facts allo or corrections set forth on the	eged	
	,				statement of deficiencies.		
	Facility number: 000447 Provider number:155551				statement of deficiencies.		
					The Plan of Correction is prepar	red	
					and submitted because of		
	AIM number:	100289950			requirements under State and Fe	ederal	
					law.		
	Surveyor: Jeri Cu	artis, RN			1477.		
					Please accept this Plan of Corre	ction	
	Census bed type:				as our credible allegation of		
	SNF/NF: 92				compliance.		
					-		
	Total: 92	2					
	Census payor typ	oe:					
	Medicare:	9					
	Medicaid:	57					
	Other:	26					
	Total:	92					
	Total.	72					
	G 1 2						
	Sample: 3						
	m 1 ~ · ·	1 (1)					
		es also reflect state					
	findings in accord	dance with 410 IAC 16.2.					
	Quality review co	ompleted on July 18,					
	2011 by Bev Fau	•					
	_311 0 _j						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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AND PLAN OF CORRECTION IDENTI		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155551	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/14/2011
	PROVIDER OR SUPPLIER		604 RE	ADDRESS, CITY, STATE, ZIP CODE ENNAKER STREET NTAINE, IN46940	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
F0225 SS=D	The facility must in have been found gor mistreating resident have had a finding nurse aide registry mistreatment of resoftheir property; a has of actions by a employee, which we service as a nurse the State nurse aide authorities. The facility must eviolations involving abuse, including ir and misappropriate reported immediate the facility and to with State law through (including to the Stagency). The facility must halleged violations and must prevent the investigation is the investigation is state survey and cover working days of the violation is verified action must be tak Based on observating the facility with facility and to the additional state survey and cover working days of the violation is verified action must be tak Based on observating the facility must be tak.	ot employ individuals who guilty of abusing, neglecting, dents by a court of law; or a entered into the State or concerning abuse, neglect, sidents or misappropriation and report any knowledge it a court of law against an would indicate unfitness for aide or other facility staff to de registry or licensing Insure that all alleged guistreatment, neglect, or ajuries of unknown source ion of resident property are ely to the administrator of other officials in accordance ough established procedures tate survey and certification ave evidence that all are thoroughly investigated, further potential abuse while are thoroughly investigated in progress. Investigations must be ministrator or his designated in to other officials in state law (including to the certification agency) within 5 e incident, and if the alleged appropriate corrective	F0225	No residents were negatively af by this practice. A thorough investigation for the allegation	0,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
FORM CMS-2	567(02-99) Previous Versio		PT1Y11 Facility	ID: 000447 If continuation sl	neet Page 2 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155551 07/14/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **604 RENNAKER STREET** ROLLING MEADOWS HEALTH CARE CENTER LA FONTAINE, IN46940 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE and thrown onto the floor was not resident on the secured Alzheimer's unit of having been beaten by staff immediately reported to the state survey and thrown onto the floor was agency and other officials in accordance completed by the Administrator on with state law for 1 (Resident A) of 3 6/30/11. The allegation was found to residents, among the sample of 3, be unsubstantiated. The allegation was reported to Indiana State Board reviewed for abuse allegations. of Health on 7/13/11. All residents The facility also failed to ensure the who make allegations of abuse have results of the investigation were reported the potential to be affected by this to the state survey agency and other deficient practice as related to the officials in accordance with state law appropriate reporting of allegations of abuse to the Indiana State within 5 working days of the incident. Department of Health. Abuse allegations are thoroughly Findings include: investigated by the facility. The facilities abuse policy has been Resident (A) was observed seated in the reviewed and no changes were indicated at this time. Facility staff activity room of the secured unit during have been re-educated regarding the the 7/13/11, 2:00 P.M., entrance tour. facility policy and procedure for Resident (A) was listening as the Activity abuse and reporting of unusual Director explained how zucchini bread occurrences and will continue to be was made. A dark purplish-red bruise was re-educated on abuse and reporting unusual occurrences at a minimum of observed to the inner left wrist. two times a year. Investigations will be immediately reported to and A former neighbor (#1) of Resident (A) reviewed by the Regional Director of was interviewed by telephone at 3:05 Operations and/or Regional Director P.M.,7/13/11, said he had visited twice of Quality Assurance this will be ongoing for all investigations. All since the admission to the facility, and allegations of abuse will be reported indicated a concern of abuse to (Resident to the Indiana State Board of Health. A) by facility staff. The Regional Director of Operations Neighbor #1 indicated Resident (A) had and/or Regional Director of Quality said 2 burly guys had sat on her for 5 Assurance will initial all investigations indicating review and hours. appropriate reporting to the Indiana Neighbor #1 indicated on the second visit, State Department of Health. Any 7/9/11, Resident (A) had told him the staff concerns noted will receive in the blue green uniforms had bounced

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Event ID:

PT1Y11

Facility ID: 000447

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155551	B. WIN			07/14/2	011
		<u> </u>		_	ADDRESS, CITY, STATE, ZIP CODE	!	
NAME OF F	PROVIDER OR SUPPLIEF	{		1	NNAKER STREET		
ROLLING	G MEADOWS HEAL	TH CARE CENTER		LA FON	ITAINE, IN46940		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	· · · · · · · · · · · · · · · · · · ·	. 1	DATE
	1	and had thrown her on			immediate follow-up. The Reg Director of Operations and/or	ional	
	the floor. Neighbor #1 indicated Resident				Regional Director of Quality		
	(A) had recognized him and his family				Assurance report of monitoring	g will	
	members and had begged them to get her				be forwarded to the Quality		
	out of the facility.				Assurance Committee for mon		
	Neighbor #1 indicated he had noticed multiple bruises on Resident (A) during the 7/9/11 visit.			1	QA review and response and the	ne plan	
					of action will be adjusted		
					accordingly.		
	During a 7/13/11	, 3:25 P.M., interview,					
	the Administrator indicated Resident (A)						
	had been unable to manage self care at						
		leath of the spouse. The					
		dicated members of the					
		doing volunteer care					
		ent (A) at her home.					
	~ ~	or indicated the care					
		decline in the condition					
	l ~	take medications					
		ng clothes inside out, and					
	1 * '	pieces of clothing at one					
	time.	pieces of clothing at one					
		or indicated the care					
		aid Resident (A) would					
	l ~	and sit for several hours					
	, , , ,						
	her some where.	one, unknown, to take					
		or indicated a friend					
	_	of attorney (POA) and					
	l ` ′	evaluated by a physician					
		led placement in a long					
	term care facility						
		or indicated Resident (A)					
	had been diagnor	sed with dementia, had					

		X1) PROVIDER/SUPPLIER/CLIA	(X	(2) MULTIP				(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A.	. BUILDING	ì	00		COMPL	
		155551	В.	WING _				07/14/2	U11
NAME OF F	PROVIDER OR SUPPLIER					DRESS, CITY, STA			
						IAKER STRE			
ROLLING	MEADOWS HEAL	LTH CARE CENTER		LA	FONTA	AINE, IN46940)		
(X4) ID		STATEMENT OF DEFICIENCIES		ID			LAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREF		CROSS-REFERENCE	'E ACTION SHOULD BE ED TO THE APPROPRIAT ICIENCY)	E	COMPLETION
TAG		LISC IDENTIFYING INFORMATION)	TAC	1	DEF	ICIENCT)		DATE
		thers rooms following							
	•	nad been transferred to the							
	secured unit. The Administrator indicated Regident (A)								
	The Administrator indicated Resident (A)								
	did not want to be at the facility and had								
	made false accusations against staff,								
	indicating she had been hit and thrown								
	onto the floor. The Administrator indicated Resident (A)								
	The Administrator indicated Resident (A)								
	was unable to identify specific staff								
	members. The Administrator indicated he								
	had done an internal investigation of the								
	allegations and found them to be false.								
		or indicated he had not							
	-	gations to the Indiana							
	•	nt of Health, the state							
		because they had been							
	determined to be	e false.							
	The Administrat	tor provided a copy of the							
		investigation for review							
	on 7/13/11.	, ,							
		eged she had been beat							
	, ,	ght, and hit and thrown on							
	-	ified nursing assistants							
	(CNAs).								
	, ,	or documented he had							
		f on duty during the							
		ne and other residents in							
	_	The Administrator							
		other residents denied							
	ever having been								
	_	or indicated Resident (A)							
		and said she had bruising							
FORM CMS-2	2567(02-99) Previous Versio		<u>_</u> : PT1`	Y11 F:	acility ID:	000447	If continuation sh	neet Pa	ge 5 of 16

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155551	B. WIN			07/14/2	011
		<u> </u>	P. (12.)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	NNAKER STREET		
		TH CARE CENTER		LA FON	ITAINE, IN46940		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	1	t was bleeding. The					
	1	dicated bruising or blood					
	were not present						
		or also documented					
	Resident (A) had	d said she had layed on					
		nours, "until they came					
	and got me." The	e Administrator also					
	documented Res	ident (A) had said she					
	was having surg	ery to have her leg cut off,					
	and had been told not to eat.						
	Documentation indicated Registered						
	Nurse (RN #1) had conducted a head to						
	1	on 7/1/11, and bruising					
	was not observed	_					
		or indicated the POA was					
		llegation on 7/1/11.					
	1	indicated the POA had					
		en Resident (A) hit					
	herself in the pas						
	nersen in the pas	51.					
	1	full body assessment of					
	Resident (A) wa	s completed by the					
	Director of Nurs	ing (DoN), and Licensed					
	Practical Nurse	(LPN #1,) the wound					
	nurse. A reddish	-blue bruise was observed					
	on the left inner	wrist. No other bruises					
	were observed.						
		techiae were observed					
	1	les on the right hand.					
	1	d swelling of the bilateral					
	1 ' '	red streaks on the left					
	knee.	100 biround on the left					
		ted the physician had					
	1						
	exammed Keside	ent (A), diagnosed					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	155551		LDING	00	07/14/2	
		100001	B. WIN		A PARAGO CITY CTATE TIN CORE	0771472	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE NNAKER STREET		
ROLLING	3 MEADOWS HEAD	TH CARE CENTER		1	ITAINE, IN46940		
	_	TATEMENT OF DEFICIENCIES		ID	I		(7/5)
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	cellulitis and had	ordered antibiotics.					
		ination Resident (A)					
	indicated 2 women and 2 men had picked						
		her onto the floor, and					
	1 *	25 hours in the cold rain.					
		s unable to describe the					
	` ′	allegedly slammed her					
	1 *	when or where the					
	incident had occurred.						
	The record of Resident (A) was reviewed						
	7/13/11, at 4:50 P.M., and indicated a						
	6/14/11, admission with diagnoses						
	including, but no	t limited to, Alzheimer's					
	dementia, and blin	ndness.					
	Resident (A) had	6/14/11,physician					
	admission orders	for Ativan (an anti					
	anxiety) every 6	hours as necessary.					
	Resident (A) had	been assessed on the					
	6/27/11, Minimu	m Data Set (MDS), with					
	a score of 4 out of	of 15 on the basic					
	intellectual menta	al exam (BIMS),					
	indicating severe	cognitive impairment.					
	The attending ph	ysician's 7/12/11,					
	examination indi	cated delusional					
	behaviors.						
	The 6/20/11, plan	n of care indicated a					
	concern of depres	ssed mood with resulting					
	confusion and be	ing upset about					
	placement in the	facility. Interventions					
	included allowing	g time for adjustment to					
	new surrounding	s, provision of activities					
	and seating Resid	dent (A) with other					
	residents who we	ere able to converse.					

AND PLAN OF CORRECTION IDENTI		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155551	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/14/2011
	ROVIDER OR SUPPLIER		604 RE	ADDRESS, CITY, STATE, ZIP CODE NNAKER STREET JTAINE, IN46940	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F0226 SS=D	(false belief) thin amputated, people mistreating her. I included assuring reassuring, and meeded. This federal tag in IN00093406. 3.1-28(c) 3.1-28(e) The facility must describe written policies and mistreatment, negular and misappropriated based on observation included the immallegation of abutagency and other agencies, in accoomagencies, in accomagencies, in accomagencies	deconcern was delusional aking that leg would be le were cursing her and The interventions gall basic needs met, mental health services as relates to Complaint evelop and implement deprocedures that prohibit lect, and abuse of residents ion of resident property. Action, record review and ceility failed to ensure ces for abuse prevention mediate reporting of an asset to the state survey appropriate state redance with state law. Failed to develop and the prevention policy that mission of the results of tigation of an allegation oppropriate state agencies gadays of the allegation of 2 residents, among reviewed for abuse	F0226	No residents were negatively affected by this practice. No residents have the potential taffected by this deficient practice buring the time of the complesurvey the facility policy and procedure for Abuse was requested and supplied. The facility policy and procedure Reporting of Unusual Occurrences was not requested and Reporting Unusual Occurrences has been review and no changes are indicated this time. The facility policy aprocedure for Abuse and Reporting Unusual Occurrences has been review and no changes are indicated this time. The facility policy aprocedure for Abuse and Reporting Unusual Occurrence includes that the facility will	to be ctice. aint for ted. al wed d at and

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Event ID: PT1Y11

Facility ID:

000447

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILI		NSTRUCTION 00	(X3) DATE S	ETED
		155551	B. WING			07/14/2	011
	PROVIDER OR SUPPLIER	TH CARE CENTER		604 REI	DDRESS, CITY, STATE, ZIP CODE NNAKER STREET TAINE, IN46940		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	P	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
	activity room of the 7/13/11, 2:00 Resident (A) was Director explained was made. A dark observed to the interpretation of the interpretation observed to the interpretation of the facility of the floor. Neighbor #1 indicated a concept of the wall, and interpretation of the facility of the f	s observed seated in the the secured unit during P.M., entrance tour. Is listening as the Activity ed how zucchini bread k purplish-red bruise was nner left wrist. For (#1) of Resident (A) by telephone at 3:05 d he had visited twice from to the facility, and the ern of abuse to (Resident eff. Is cated Resident (A) had so had sat on her for 5 deated on the second visit, (A) had told him the staff in uniforms had bounced and had thrown her on for #1 indicated Resident ed him and his family dibegged them to get her			ensure all allegations of mistreatment, neglect, or abi including injuries of unknowr source, are reported immedi to the Administrator of the fa and to other officials in accordance with state law through established procedu (Including to the state survey certification agency). The Administrator and/or other officials shall notify ISDH in accordance with ISDH guide Please be aware we are requesting paper compliance related to this deficiencies.	n ately cility res / and	

000447

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155551			LDING	NSTRUCTION 00	(X3) DATE S COMPL 07/14/2	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF	PROVIDER OR SUPPLIEF	₹		1	NNAKER STREET		
		LTH CARE CENTER			ITAINE, IN46940		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL SELSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
IAG	†	or indicated Resident (A)		IAG	,		DATE
		to manage self care at					
		leath of the spouse. The					
		dicated members of the					
		doing volunteer care					
		ent (A) at her home.					
	~ ~	or indicated the care					
		decline in the condition					
	-						
	with a failure to take medications correctly, wearing clothes inside out, and						
	layering several pieces of clothing at one						
	time.						
	The Administrator indicated the care						
		said Resident (A) would					
	-	and sit for several hours					
		eone, unknown, to take					
	her some where.						
		or indicated a friend					
		of attorney (POA) and					
	_	evaluated by a physician					
		led placement in a long					
	term care facility						
	· ·	or indicated Resident (A)					
		sed with dementia, had					
		thers rooms following					
		nad been transferred to the					
	secured unit.	iad been transferred to the					
		or indicated Resident (A)					
		be at the facility and had					
		sations against staff,					
		ad been hit and thrown					
	onto the floor.	ia occii iiit ana unown					
		or indicated Resident (A)					
		* *					
	was unable to 10	entify specific staff					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	155551		LDING	00	07/14/2	
		100001	B. WIN		A DDDEGG CITY CTATE 7ID CODE	0771472	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE NNAKER STREET		
ROLLING	G MEADOWS HEAL	TH CARE CENTER		1	ITAINE, IN46940		
(X4) ID	_	TATEMENT OF DEFICIENCIES		ID	, 		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	members. The Ad	dministrator indicated he					
	had done an inter	rnal investigation of the					
	allegations and found them to be false.						
	The Administrate	or indicated he had not					
	reported the alleg	gations to the Indiana					
	State Department	t of Health, the state					
	survey agency, b	ecause they had been					
	determined to be	false.					
	The Administrat	or provided a copy of the					
	6/30/11, internal investigation for review						
	on 7/13/11.						
	Resident (A) alle	ged she had been beat					
	up, cursed all nig	tht, hit, and thrown on the					
	floor by certified	nursing assistants					
	(CNAs).						
	The Administrate	or documented he had					
	interviewed staff	on duty during the					
	alleged time fram	ne and other residents in					
	the secured unit.	The Administrator					
	documented the	other residents denied					
	ever having been	mistreated.					
	The Administrate	or indicated Resident (A)					
	was interviewed	and said she had bruising					
	on her face and it	t was bleeding. The					
	Administrator in	dicated bruising or blood					
	were not present	on the face.					
	The Administrate	or also documented					
	Resident (A) had	said she had lain on the					
		s, "until they came and					
	got me." The Adı	ministrator also					
	documented Resi	ident (A) had said she					
		ery to have her leg cut off,					
	and had been told	d not to eat.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ì		INSTRUCTION 00	(X3) DATE S COMPL		
		155551	A. BUI B. WIN	LDING G		07/14/2	011
	PROVIDER OR SUPPLIER MEADOWS HEAL	TH CARE CENTER		STREET A	ADDRESS, CITY, STATE, ZIP CODE NNAKER STREET ITAINE, IN46940		
(X4) ID PREFIX TAG	(EACH DEFICIENG REGULATORY OR Documentation in	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) Indicated Registered		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Nurse (RN #1) had toe assessment of was not observed. The Administrate notified of the all Documentation is stated he had see herself in the pass. At 4:15 P.M., a fractical Nurse (nurse. A reddishon the left inner were observed. Several small pet across the knuck! Resident (A) had extremities with a knee. The DoN indicate examined Reside cellulitis and had During the examindicated 2 women her up, slammed she had laid for 2 Resident (A) was persons who had onto the floor, or	ad conducted a head to n 7/1/11, and bruising l. or indicated the POA was allegation on 7/1/11. Indicated the POA had en Resident (A) hit t. full body assessment of a completed by the lang (DoN), and Licensed LPN #1,) the wound blue bruise was observed wrist. No other bruises techiae were observed les on the right hand. It swelling of the bilateral red streaks on the left ed the physician had ent (A), diagnosed lordered antibiotics. Ination Resident (A) en and 2 men had picked her onto the floor, and les hours in the cold rain. It is unable to describe the allegedly slammed her when or where the					
	incident had occu	micu.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155551	(X2) M ¹ A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/14/2011		
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
ROLLING MEADOWS HEALTH CARE CENTER				1	NNAKER STREET			
					ITAINE, IN46940			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE	
	The record of R	esident (A) was reviewed						
		P.M., and indicated a						
	6/14/11, admission with diagnoses							
	· ·	ot limited to, Alzheimer's						
	dementia, and bli	ndness.						
	Resident (A) had	d 6/14/11,physician						
	admission orders	s for Ativan (an anti						
	anxiety) every 6	hours as necessary.						
	Resident (A) had	l been assessed on the						
	6/27/11, Minimu	ım Data Set (MDS), with						
	a score of 4 out	of 15 on the basic						
	intellectual ment	al exam (BIMS),						
	indicating severe cognitive impairment.							
	The attending pl	nysician's 7/12/11,						
	examination ind	icated delusional						
	behaviors.							
	The 6/20/11, pla	n of care indicated a						
	1	essed mood with resulting						
	confusion and being upset about							
	placement in the facility. Interventions							
		g time for adjustment to						
	_	s, provision of activities						
		dent (A) with other						
		ere able to converse.						
		d concern was delusional						
	1 '	nking that leg would be						
		le were cursing her and						
	1	The interventions						
		g all basic needs met,						
	_	mental health services as						
	needed.							
	The Administrat	or had provided the						
		or had provided the Administrative Abuse						
	1 1acmity 8 10/03, 1	Aumminsuative Abuse						

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED 07/14/2011	
		155551	B. WIN			07/14/2	011	
NAME OF PROVIDER OR SUPPLIER				1	ADDRESS, CITY, STATE, ZIP CODE			
				1	NNAKER STREET ITAINE, IN46940			
	ROLLING MEADOWS HEALTH CARE CENTER			<u> </u>	TAINE, IN40940			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD				
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
1710		ram at 4:00 P.M.,	+	1110			DITTE	
	_	licy indicated residents						
	•	be free of abuse, neglect,						
	_	of property, corporal						
		involuntary seclusion.						
	pumsimient, and	mivolumary sectusion.						
	 Point #3 indicate	ed comprehensive policies						
		and been developed to aid						
	in preventing abu	•						
		residents. The policies						
		governed at a minimum:						
		ployment background						
	checks.							
	Mandated staff training/orientation							
	programs that included preventing abuse,							
	neglect, or mistreatment of residents.							
	-	occurrences of potential						
	mistreatment/abu							
	Protection of residents during abuse							
	investigations.							
	•	ough investigations of all						
	reports or allegat							
	Reporting and fil							
		ve to incidents of abuse.						
		and analysis of abuse						
	incidents.	,						
		of changes to prevent						
	future occurrence	-						
	This federal tag r	relates to Complaint						
	IN00093406.	•						
	3.1-28(a)							
	. ,							

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155551			A. BUILDING B. WING	00	COMP	COMPLETED 07/14/2011	
NAME OF PROVIDER OR SUPPLIER ROLLING MEADOWS HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 604 RENNAKER STREET LA FONTAINE, IN46940				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155551	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM 07/14	E SURVEY PLETED '2011
NAME OF PROVIDER OR SUPPLIER ROLLING MEADOWS HEALTH CARE CENTER			604 RE	ADDRESS, CITY, STATE, ZIP C ENNAKER STREET NTAINE, IN46940	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE